Letters to the editor

WAKE THERAPY

DEAR EDITOR:

As an inpatient psychiatrist, I was intrigued to read in the September issue of *Psychiatry 2008* Feifel's article on wake therapy as a viable intervention in the management of patients hospitalized with treatment-resistant depression ("Transforming the Psychiatric Inpatient Unit from Short-term Pseudo-asylum Care to State-of-the-art Treatment Setting").[1] Dr Feifel correctly reiterates that wake therapy is the most rapidly acting antidepressant strategy.[2] Yet it is sadly underutilized. Sixty percent of depressed patients experience substantial improvement after a total night of sleep deprivation. However, the antidepressant effect is lost the following day. Berger et al[3] described a procedure wherein the antidepressant benefits derived from a single night of sleep deprivation were sustained with a simple sleep phase advance intervention. In their wake therapy protocol, conducted on an inpatient psychiatric unit in Freiburg, Germany, patients diagnosed with major depressive disorder were kept up on Day 1. On Day 2, they went to bed from 5:00 pm to 12:00 midnight, and gradually postponed their bedtime by an hour each subsequent night, till they arrived at a bedtime of 11:00 pm to 6:00 am. The process was completed in eight consecutive days. This is a longer interval than the average length of stay for patients hospitalized with depression in the US. On the inpatient psychiatry unit at St Lawrence/Sparrow Hospital in Lansing, Michigan, we abbreviated the sleep phase advance procedure to four days, by postponing sleep time by two hours rather than one hour each day. Following a night of total sleep deprivation, the patients were asked to go to bed at 5:00 pm, 7:00 pm, and 9:00pm on Days 2, 3, and 4, respectively, seeking to sustain the antidepressant benefit. We permitted the use of caffeine and hypnotics to facilitate the procedure. We encountered obstacles: Patients hospitalized on inpatient psychiatric units are required to adhere to a highly regimented sleep-wake schedule. The necessary 15-minute visual patient safety checks and environmental noise often disrupted sleep continuity. The introduction of a wake-therapy intervention required a change of mindset. Nevertheless, considering the limited efficacy of antidepressant medications[4] in treatment-resistant depression, wake therapy needs to be more widely employed as a viable therapeutic option.

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With regards,

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AUTHOR REPONSE

Dr. D'Mello raises good points in his letter. Sleep phase-advance is one of the procedures being explored to counter the transitory benefit of wake therapy as is the morning light therapy we employ at UCSD. His use of caffeine and hypnotics to facilitate sleep advance is interesting. We have recently begun to utilize modafinil with success to facilitate wake therapy in consenting patients. Given its documented antidepressant-augmenting effect, the use of modafinil in this way seems rational.

Kudos to Dr. D'Mello for striving to impliment procedures such as this to enhance the treatment of inpatients admitted to his hospital unit as we are at UCSD Medical Center. As Dr. D'Mello points out, these nonpharmacological techniques, so highly suitable for an inpatient setting, are underutilized, especially given their favorable benefit to risk and cost ratio. We need more inpatient psychiatrists to become aware of and willing to impliment these available interventions in order to advance and elevate the standard of care for inpatient psyhiatric units.

With regards,

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